

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14200

CERTIFICATE OF DEATH

14209

1. DECEASED-NAME (Type or print) William D. Anderson			2a. DATE OF DEATH Month 10 Day 19 Year 68			2b. HOUR 10 P			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH 6-17-1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.			
10. CITY OR TOWN OF DEATH Greensboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER None	
14. FATHER'S NAME First Middle Last John Anderson			15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Hurd						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-22-7153		17. INFORMANT Iva B. Hopkins		Address Norfolk, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Arteriosclerotic Cardiovascular Dis. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Obstructive Pul. Emphysema, Chr. Bronchial Asthma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1967 , to Oct. 19, 1968 , that (I) (we) lost saw the deceased alive on Oct. 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles H. Stonesifer, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 21 '68	
22d. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.				22e. ADDRESS Greensboro, Md. 21639					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-22-68		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro Caroline Md			
24. FUNERAL DIRECTOR John S. Boulton				ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR OCT 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Charles H. [Signature]

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
WILLIAM		TIMOTHY		HOLLEY				Month Day Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years)		7. DATE PRONOUNCED DEAD	
Male		White		March 26, 1895		73 YRS		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH	
West Virginia		USA		WIDOWED		DIVORCED		Caroline	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Federalsburg		R.F.D. #2		Retired Mechanic		Canning			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		112 Willis Street	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Ira J. Holley								Laura J. Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		214-07-8700		Mrs. Esther M. Holley, Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Coronary Occlusion								minutes	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic Heart Disease								?	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201 Diabetes mellitus Controlled									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		HOUR A.M. P.M.		19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		M.D.		DEPUTY MEDICAL EXAMINER		10/19/68			
Arnold B. Plummer M.D.				ADDRESS (Street, city, town, or county)		Preston Caroline			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Oct 22, 1968		Eldorado Cemetery		Eldorado, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. J. Frampton and Son, Federalsburg, Md.						OCT 23 1968		[Signature]	

14210

WILLIAM TIMOTHY HOLLEY

White Birch 26, 1927 V3

West Virginia USA

Harvard University Cambridge MA 02138

Lawrence J. Miller

114-07-10000, Bishop K. Holley, Cambridge, MA

Harvard University Cambridge MA 02138

J. J. Frawley and Son, Federalburg, MD

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14202

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14211

1. DECEASED-NAME (Type or print) First Middle Last KATE QUILLIN LONG			2a. DATE OF DEATH Month Day Year October 8 1968			2b. HOUR 8:05 A. M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH November 25, 1883		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Berlin, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.					
10. CITY OR TOWN OF DEATH Federalsburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 119 West Central Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 119 W. Central Avenue		
14. FATHER'S NAME First Middle Last Samuel M. Quillin			15. MOTHER'S MAIDEN NAME First Middle Last Amantha (maiden name unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-03-2387		17. INFORMANT Address Henry Q. Long, Hampton, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 442											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 31, 1965, to Oct 8, 1968, that (I) (we) last saw the deceased alive on 10-8-68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank M. Anderson DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 10-9-68					
22d. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.				22e. ADDRESS Federalsburg, Md. 21632							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland					
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.				25a. REC'D BY REGISTRAR DATE OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14203												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14212			
1. DECEASED-NAME (Type or print) Rosa Seiler												2a. DATE OF DEATH 10 Month 4 Day 1968												2b. HOUR 1155A			
3. SEX Female				4. RACE White				5. DATE OF BIRTH Sept. 6, 1886				6. AGE (In years last birthday) 82 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Hungary				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Caroline Md.															
10. CITY OR TOWN OF DEATH Rural Henderson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY None															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland				13b. COUNTY Caroline				13c. CITY OR TOWN Henderson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER None											
14. FATHER'S NAME First Middle Last No Record						15. MOTHER'S MAIDEN NAME First Middle Last No Record																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. Unknown				17. INFORMANT Address John Seiler Henderson, Maryland															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Arteriosclerotic C.V. Disease</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u> <u>Diabetes Mellitus</u>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19, 1968</u> , to <u>Oct. 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <u>Charles H. Stonifer</u>				DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED Oct. 5, 1968															
22d. PHYSICIAN'S NAME (Type) Charles H. Stonifer, M.D.				22e. ADDRESS Greensboro, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 10-7-68				23c. NAME OF CEMETERY OR CREMATORY Templeville				23d. LOCATION (City or Town) (County) (State) Templeville, Maryland															
24. FUNERAL DIRECTOR <u>J. E. Bouclair</u>				ADDRESS <u>Greensboro, Md.</u>				25a. REC'D BY REGISTRAR DATE OCT 9 1968				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

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TECHNICAL OF PLAIN

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Letter

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Handwritten signature: Charles A. E. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
LINWOOD		JOSEPH		SHOCKLEY, SR.		October 20		1968		3 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		April 6, 1910		58 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Caroline Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Federalsburg		R.F.D. (Hurlock Rd.)		Mill Sawyer and Farmer							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Caroline		Federalsburg		NO <input checked="" type="checkbox"/>		R.F.D.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
Joseph Shockley				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No		218-12-1299		Mrs. Hazel Shockley, Federalsburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>										0	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u>										6 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u>										10 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201 <u>Compound comminuted Fracture - patella - June 9, 1967</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>61</u> , to <u>Oct 18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>October 18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<u>H. R. Trapnell</u>		Oct. 22, 1968									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
H. R. Trapnell, M.D.		Federalsburg, Maryland									
23a. BURIAL, CREMATION, REINTERMENT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Oct. 23, 1968		St. Andrews Cemetery		Princess Anne, Maryland					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
J. J. Frampton and Son, Federalsburg, Md.		OCT 23 1968		<u>Charles Judge</u>							

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October 10 1968

April 5, 1910

Caroline

Federalburg

Caroline

Unknown

1941-1959

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

October 10 1968

CERTIFICATE OF DEATH

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14214

1. DECEASED-NAME (Type or print) SARAH First LULA Middle SMITH Last			2a. DATE OF DEATH Month OCT Day 7 Year 1968		2b. HOUR 6:15 A M
3. SEX F	4. RACE N	5. DATE OF BIRTH SEPT 19, 1890		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline Md.		
10. CITY OR TOWN OF DEATH RIDGELY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AS HOME	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY CAROLINE	13c. CITY OR TOWN RIDGELY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME JAMES First DOBSON Middle Last	15. MOTHER'S MAIDEN NAME MARY First CHASK Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT MRS. BEATRICE STAFFORD Address RIDGELY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 Hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/2 , 19 66 , to 9/7 , 19 68 , that (I) (we) last saw the deceased alive on 9/7/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Philip P Felipe MD	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/10/68
22d. PHYSICIAN'S NAME (Type) Philip P Felipe MD	22e. ADDRESS DENTON MD 21629				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE OCT 12, 1968	23c. NAME OF CEMETERY OR CREMATORY NEW CHAPEL	23d. LOCATION (City or Town) (County) (State) EASTON TALBOT MD.		
24. FUNERAL DIRECTOR CHARLES F. MOORE	ADDRESS DENTON, MD.	25a. REC'D BY REGISTRAR OCT 14 1968	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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14206

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Willie Thomas Sturgis			2a. DATE OF DEATH Month Day Year 10 16 1968		2b. HOUR M AM
3. SEX Male	4. RACE Col.		5. DATE OF BIRTH 3-6-1892		6. AGE (In years last birthday) 76 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline Md.
10. CITY OR TOWN OF DEATH Rural Greensboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Opilins Nursing Home		12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if retired.) Laborer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Pocomoke	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Middle Last Charles Sturgis			15. MOTHER'S MAIDEN NAME First Middle Last No Record		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-38-1532	17. INFORMANT Address Chester Sturgis Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Arrested/Tuberculosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1968 , to Oct. 16, 1968 , that (I) (we) last saw the deceased alive on Oct. 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Stonesifer, M.D.				22c. DATE SIGNED Oct. 17 '68	
22d. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22e. ADDRESS Greensboro, Maryland 21639			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-19-68		23c. NAME OF CEMETERY OR CREMATORY Wardtown	
23d. LOCATION (City or Town) (County) (State) Pocomoke, Maryland		25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14207				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14216			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) NETTIE MAY TALLMAN				2a. DATE OF DEATH OCT 27 1968				2b. HOUR M			
3. SEX F		4. RACE W		5. DATE OF BIRTH JUNE 3, 1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CAROLINE Md.					
10. CITY OR TOWN OF DEATH DENTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CAROLINE		13c. CITY OR TOWN DENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First CLEM Middle JESTER Last WHEELER		15. MOTHER'S MAIDEN NAME First ROSALIE Middle WHEELER Last WHEELER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ROLAND JESTER Address DENTON							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic Heart Disease (b) Amyocardium + embolism (c) Diabetic Mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetic Mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7/21/68 to 10/22/68 , that (I) (we) last saw the deceased alive on 10/22/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. A. Anderson DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/28/68			
22d. PHYSICIAN'S NAME (Type) W. A. Anderson, M.D.				22e. ADDRESS Court House Green, Denton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE OCT 30, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD.					
24. FUNERAL DIRECTOR J. VIRGIL MOORE & SON, DENTON ADDRESS				25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

1931

CERTIFICATE OF DEATH

1931

WILLIE MAY JAMES

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14208		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14217	
1. DECEASED-NAME (Type or Print)						2a. DATE KNOWN OF DEATH	
First		Middle		Last		Month Day Year	
Leslie		Wyatt				10-2 68	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	2-16-1916	52 YRS.	MONTHS DAYS	HOURS MIN.	10 Month 2 Day 1968	12 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Delaware		U.S.A.				Caroline	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Rural Greensboro		Rt 313 & Knife Box Rd.		Oil Distributor		Oil	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Caroline		Greensboro		Sunset Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Oscar		Wyatt		Effie		Cooper	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWII		219-07-8124		Mary L. Wyatt Greensboro, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3/4 Decapitation 8169 DUE TO, OR AS A CONSEQUENCE OF (b) Automobile accident turning car over Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8234 (c) 0.18 % Ethyl Alcohol APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds seconds ?hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary arteriosclerosis with insufficiency 4-5 yrs							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		12-29-10/2/68		Ran off of road turned over			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
		113 & Knife Box Road		RFD Greensboro Maryland Caroline			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
Dr. Harold B. Plummer		Dr. Harold B. Plummer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10/9/68	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
						Preston Caroline	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		10-4-68		Greensboro		Greensboro, Maryland	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J.E. Boulaire Greensboro, Md.				OCT 11 1968		Charles Judge	

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